

<b>DEPENDENCY STATEMENT - WARD OF A COURT</b>	CONTROL NUMBER	<i>Form Approved</i> <i>OMB No. 0730-0014</i> <i>Expires May 31, 2004</i>
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<b>PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO YOUR LOCAL SERVING PERSONNEL/PAYROLL OFFICE.</b>		
<b>PRIVACY ACT STATEMENT</b>		
<b>AUTHORITY:</b> 37 U.S.C. Chapter 7; 10 U.S.C. Chapter 55; EO 9397, November 1943. <b>PRINCIPAL PURPOSE:</b> To obtain information to determine dependency upon service member. <b>ROUTINE USE(S):</b> Copies of the dependency statement, related correspondence, and information from either may be furnished to the FBI for law enforcement; the IRS and state and local taxing agencies for tax administration; the VA to determine entitlement and prevent duplication of payment; the Defense Finance and Accounting Service for final determination in appeal cases; welfare agencies to prevent duplication of payment; and the American Red Cross (ARC) for locator purposes and to aid in delinquent loans owed to ARC. <b>DISCLOSURE:</b> Voluntary; however, the SSN is used for positive identification and if the required information is not furnished, the member's application may be disapproved.		
<b>INSTRUCTIONS</b>		
This form is used to determine Basic Allowance for Housing (BAH), travel allowances, and/or Uniformed Services Identification and Privilege (USIP) card benefits for wards of a court. The member must complete the form as stated in Item 3, sign and date the form, and have it notarized. Answer every question. If any question does not apply, write "NOT APPLICABLE" or "N/A" in that block. Report and verify any income in gross amounts. Verification of income, proof of support and a copy of guardianship documents are required. In the case of a ward who is a full-time student, supporting documentation must include a letter from the accredited college or university verifying the ward's full-time enrollment, documentation of expenses, and any educational assistance that ward may receive. If the ward is incapacitated and over the age of 21, a medical sufficiency statement from a military medical treatment facility is required.		
<b>1. ENTITLEMENTS REQUESTED</b> <i>(X and complete as applicable)</i>		
<b>a. TYPE</b> <input type="checkbox"/> BAH <input type="checkbox"/> USIP <input type="checkbox"/> TRAVEL ALLOWANCE	<b>b. FIRST APPLICATION?</b> <input type="checkbox"/> YES <i>(If "NO," give date of last application)</i> <input type="checkbox"/> NO <i>(YYYYMMDD)</i> _____	<b>c. LAST APPLICATION WAS</b> <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED
<b>2. MEMBER INFORMATION</b>		
<b>a. NAME</b> <i>(Last, First, Middle Initial)</i>		<b>b. SSN</b>
		<b>c. RANK</b>
<b>d. STATUS</b> <i>(X and complete as applicable)</i>		
<input type="checkbox"/> ACTIVE DUTY	<input type="checkbox"/> NATIONAL GUARD	<input type="checkbox"/> ARMY
<input type="checkbox"/> RETIRED	<input type="checkbox"/> RESERVE	<input type="checkbox"/> MARINE CORPS
		<input type="checkbox"/> NAVY
		<input type="checkbox"/> AIR FORCE
		<input type="checkbox"/> DECEASED <i>(Date of death) (YYYYMMDD)</i> _____
		<input type="checkbox"/> OTHER <i>(Specify)</i> _____
<b>e. COMPLETE RESIDENCE ADDRESS</b> <i>(Street, Apartment Number, City, State, ZIP Code)</i>		
<b>f. COMPLETE MILITARY ADDRESS</b> <i>(Include assignment: squadron and base)</i>		
<b>g. TELEPHONE NUMBERS</b> <i>(Include DSN or Area Code)</i>		<b>h. E-MAIL ADDRESS</b>
(1) WORK	(2) HOME	
		<b>i. MARITAL STATUS</b> <i>(X)</i>
		<input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED
		<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED
<b>3. WARD INFORMATION</b>		
<b>a. NAME</b> <i>(Last, First, Middle Initial)</i>		<b>b. SSN</b>
		<b>c. DATE OF BIRTH</b> <i>(YYYYMMDD)</i>
<b>d. COMPLETE RESIDENCE ADDRESS</b> <i>(Street, Apartment Number, City, State, ZIP Code)</i>		
<b>e. STATUS</b> <i>(X and complete as applicable)</i>		
<input type="checkbox"/> UNMARRIED UNDER 21 YEARS OF AGE <i>(Complete Items 1 - 8 and 13 - 16.)</i>		
<input type="checkbox"/> 21-22 YEARS OF AGE AND A FULL-TIME STUDENT <i>(Complete Items 1 - 9 and 12 - 16.)</i>		
<input type="checkbox"/> INCAPACITATED OVER AGE 21 <i>(Complete Items 1 - 8 and 10 - 16.)</i>		
<b>HAS WARD EVER BEEN MARRIED?</b> <i>(If "Yes," attach copy of annulment decree, final divorce decree, or death certificate of ward's spouse.)</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO		

4. WARD'S RESIDENCE

a. TYPE OF RESIDENCE (X and complete as applicable)

<input type="checkbox"/>	HOME OR APARTMENT OF MEMBER	<input type="checkbox"/>	HOME OR APARTMENT OF FRIEND OR RELATIVE <i>(State relationship)</i>
<input type="checkbox"/>	HOME OR APARTMENT OF WARD		
<input type="checkbox"/>	HOME OR APARTMENT OF FORMER SPOUSE OF MEMBER	<input type="checkbox"/>	STUDENT DORMITORY OR OTHER ON-CAMPUS FACILITY
<input type="checkbox"/>	HOSPITAL OR INSTITUTION	<input type="checkbox"/>	OTHER <i>(Explain)</i>

b. OWNER OF RESIDENCE	
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(1) NAME (Last, First, Middle Initial)	(2) ADDRESS (Street, Apartment Number, City, State, ZIP Code)

c. IS RESIDENCE SUBSIDIZED HOUSING? <input type="checkbox"/> YES <input type="checkbox"/> NO	d. DATE WARD BEGAN LIVING AT CURRENT ADDRESS (YYYYMMDD)	e. DATE WARD BEGAN LIVING WITH PERSON WHO CURRENTLY HAS PHYSICAL CUSTODY (YYYYMMDD)
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5. IF WARD IS A FULL-TIME STUDENT

a. ADDRESS WHERE WARD RESIDES WHILE ATTENDING SCHOOL (Street, Apartment Number, City, State, ZIP Code)

b. TYPE OF RESIDENCE (X and complete as applicable)

<input type="checkbox"/>	WARD'S OWN HOME OR APARTMENT	<input type="checkbox"/>	STUDENT DORMITORY OR OTHER ON-CAMPUS FACILITY
<input type="checkbox"/>	MEMBER'S HOME OR APARTMENT	<input type="checkbox"/>	HOME OR APARTMENT OF FRIEND OR RELATIVE <i>(State relationship)</i>
<input type="checkbox"/>	HOME OR APARTMENT OF MEMBER'S FORMER SPOUSE		
<input type="checkbox"/>	HOME OR APARTMENT OR MEMBER'S WIDOW OR WIDOWER	<input type="checkbox"/>	OTHER <i>(Explain)</i>

c. ADDRESS WHERE WARD RESIDES WHILE NOT ATTENDING SCHOOL (Longer than 90 days) (Street, Apartment Number, City, State, ZIP Code)

d. TYPE OF RESIDENCE (X and complete as applicable)

<input type="checkbox"/>	WARD'S OWN HOME OR APARTMENT	<input type="checkbox"/>	STUDENT DORMITORY OR OTHER ON-CAMPUS FACILITY
<input type="checkbox"/>	MEMBER'S HOME OR APARTMENT	<input type="checkbox"/>	HOME OR APARTMENT OF FRIEND OR RELATIVE <i>(State relationship)</i>
<input type="checkbox"/>	HOME OR APARTMENT OF MEMBER'S FORMER SPOUSE		
<input type="checkbox"/>	HOME OR APARTMENT OR MEMBER'S WIDOW OR WIDOWER	<input type="checkbox"/>	OTHER <i>(Explain)</i>

6. PERSONS LIVING IN HOUSEHOLD WITH WARD

[illegible]

## 7. HOUSEHOLD EXPENSES

List the household expenses for all persons living in the home. If expense was one-time only, such as purchase of a new chair, do not show this as a monthly expense; list it as an expense for the past 12 months. If ward resides in the member's household or in a dwelling owned by member, use Fair Rental Value (FRV) for dwelling. If ward does not reside in member's household or in a dwelling owned by member, list actual mortgage, rent, or FRV if dwelling is mortgage-free. If FRV is used, give a brief explanation of how Fair Rental Value was obtained in the Remarks section.

FAIR RENTAL VALUE (FRV): FRV is a single monthly sum for the entire dwelling where the ward lives. This sum is an amount the owner can reasonably expect to receive from a stranger to rent the dwelling. FRV will not include food, utilities, furniture, and home repairs, which are listed separately.

ITEM		PRESENT MONTHLY EXPENSE	TOTAL EXPENSE FOR PAST 12 MONTHS	ITEM	PRESENT MONTHLY EXPENSE	TOTAL EXPENSE FOR PAST 12 MONTHS
a. (X one)				d. FURNITURE/APPLIANCES		
<input type="checkbox"/>	RENT <input type="checkbox"/> FRV					
<input type="checkbox"/>	MORTGAGE (Specify amount of tax and insurance if applicable)			e. REPAIRS ON HOME		
	TAX			f. OTHER (Specify)		
	INSURANCE					
b. FOOD						
c. UTILITIES (Heat, power, water, and telephone)						

**8. WARD'S PERSONAL EXPENSES**

List personal expenses for ward. Do not list personal expenses for the member, his or her immediate family, or any other person. List all of the ward's personal expenses regardless of who is paying for them.

ITEM	PRESENT MONTHLY EXPENSE	TOTAL EXPENSE FOR PAST 12 MONTHS	ITEM	PRESENT MONTHLY EXPENSE	TOTAL EXPENSE FOR PAST 12 MONTHS
a. CLOTHING			g. PRIVATE AUTO PAYMENTS (If auto is registered in ward's name)		
b. LAUNDRY AND DRY CLEANING			h. MONTHLY TRANSPORTATION PAYMENTS (Include gas, oil, insurance, repairs, and public transportation)		
c. MEDICAL (Do not include expenses paid by insurance, welfare, or Medicare)			i. SCHOOL EXPENSES (Itemize)		
d. VALUE OF USIP CARD (Verification of amount is required)			j. OTHER EXPENSES (Itemize)		
e. PERSONAL INSURANCE (Specify)					
f. PERSONAL TAXES (Specify)					

**9. WARD'S SCHOOL EXPENSES**

List ward's school expenses even if covered by scholarship, grant, or other financial aid.

ITEM	AVERAGE MONTHLY EXPENSE	ITEM	AVERAGE MONTHLY EXPENSE
a. TUITION		e. BOARD (Food)	
b. BOOKS		f. OTHER SCHOOL EXPENSES (Specify)	
c. SPECIAL FEES			
d. ROOM (Rent)			

**10. IF WARD IS IN HOSPITAL OR INSTITUTION (INCAPACITATED)**

If ward is in a hospital or institution, all of the following information must be furnished. Obtain this information from the hospital or institution.

a. DATE WARD ENTERED HOSPITAL/INSTITUTION (YYYYMMDD)		b. ANTICIPATED DATE OF DISCHARGE (If known)			
c. WILL WARD RETURN TO MEMBER'S HOME AFTER DISCHARGE? (If "NO," explain where ward will reside)					
<input type="checkbox"/> YES <input type="checkbox"/> NO					
d. WARD'S EXPENSES IN HOSPITAL OR INSTITUTION					
ITEM	PRESENT MONTHLY EXPENSE	TOTAL EXPENSE FOR PAST 12 MONTHS	ITEM	PRESENT MONTHLY EXPENSE	TOTAL EXPENSE FOR PAST 12 MONTHS
(1) ROOM			(8) EDUCATION		
(2) FOOD			(9) TRANSPORTATION		
(3) REHABILITATION CLASSES OR SERVICES			(10) PERSONAL INSURANCE (Specify)		
(4) SPECIALIZED EQUIPMENT			(11) OTHER (Specify)		
(5) MEDICAL CARE					
(6) CLOTHING					
(7) LAUNDRY/DRY CLEANING					

10.e. WARD'S EXPENSE IN HOSPITAL OR INSTITUTION ARE PAID BY:						
SOURCE		PRESENT MONTHLY EXPENSE	TOTAL EXPENSE FOR PAST 12 MONTHS	SOURCE		TOTAL EXPENSE FOR PAST 12 MONTHS
U S I P  C A R D	(1) CIVILIAN MEDICAL TREATMENT FACILITY (CHAMPUS)			(4) STATE OR LOCAL AGENCY <i>(Name and Address)</i>		
	(2) MILITARY MEDICAL TREATMENT FACILITY					
	(3) PRIVATE INSURANCE <i>(Name and Address)</i>			(5) MEMBER		
				(6) OTHER <i>(Explain and give name and address)</i>		

  

<b>11. WARD'S EMPLOYMENT</b> Has ward been employed since age 21? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES," furnish the following information. Use the Remarks section to continue if necessary.						
a.	(1) NAME OF EMPLOYER	(2) DATE EMPLOYMENT STARTED	(3) DATE ENDED	(4) MONTHLY SALARY <i>(Gross)</i>		
	(5) TYPE OF WORK PERFORMED		(6) REASON EMPLOYMENT ENDED			
b.	(1) NAME OF EMPLOYER	(2) DATE EMPLOYMENT STARTED	(3) DATE ENDED	(4) MONTHLY SALARY <i>(Gross)</i>		
	(5) TYPE OF WORK PERFORMED		(6) REASON EMPLOYMENT ENDED			
c.	(1) NAME OF EMPLOYER	(2) DATE EMPLOYMENT STARTED	(3) DATE ENDED	(4) MONTHLY SALARY <i>(Gross)</i>		
	(5) TYPE OF WORK PERFORMED		(6) REASON EMPLOYMENT ENDED			
d. IS OR WAS WARD'S JOB CONSIDERED AS BEING A "SHELTERED WORKSHOP" - THAT IS, OPEN ONLY TO DISABLED OR HANDICAPPED PEOPLE? <input type="checkbox"/> YES <i>(If "YES" and ward is currently working, attach a statement from the employer verifying this information.)</i> <input type="checkbox"/> NO						

  

<b>12. WARD'S SCHOOL ATTENDANCE</b> Has ward attended college since age 21? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES," furnish the following information.						
a.	(1) NAME AND ADDRESS OF SCHOOL				(2) <i>(X as applicable)</i>	
					<input type="checkbox"/> VOCATIONAL <input type="checkbox"/> FOR RECEIVING DEGREE	
	(3) DATES ATTENDED			(4) (X) <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	(5) WARD'S MAJOR	
b.	(1) NAME AND ADDRESS OF SCHOOL				(2) <i>(X as applicable)</i>	
					<input type="checkbox"/> VOCATIONAL <input type="checkbox"/> FOR RECEIVING DEGREE	
	(3) DATES ATTENDED			(4) (X) <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	(5) WARD'S MAJOR	

  

<b>13. WARD'S INCOME</b> All gross income received by or in behalf of the ward, whether taxable or nontaxable, and whether received monthly, quarterly, or yearly, must be listed. This includes any income received by persons in the capacity of custodian or administrator for the ward. If any income received during the past 12 months was a lumpsum (one-time) payment, be sure to state this. Verification documents are required.						
SOURCE		PRESENT MONTHLY INCOME	TOTAL INCOME FOR PAST 12 MONTHS	SOURCE		TOTAL INCOME FOR PAST 12 MONTHS
a. WAGES, SALARIES, TIPS, OR OTHER CASH GRATUITIES  b. INTEREST ON INVESTMENTS, BONDS, SAVINGS, TRUST FUNDS, ETC.  c. INSURANCE OR PUBLIC/ GOVERNMENT PENSION PAYMENTS, UNEMPLOYMENT OR DISABILITY COMPENSATION <i>(Specify type)</i>				d. SOCIAL SECURITY PAYMENTS, DISABILITY OR REGULAR <i>(Specify)</i>  e. SUPPLEMENTAL SECURITY INCOME (SSI)  f. VETERANS ADMINISTRATION PAYMENTS <i>(Specify type)</i>		

<b>13. WARD'S INCOME</b> <i>(Continued)</i>					
SOURCE	PRESENT MONTHLY INCOME	TOTAL INCOME FOR PAST 12 MONTHS	SOURCE	PRESENT MONTHLY INCOME	TOTAL INCOME FOR PAST 12 MONTHS
g. CONTRIBUTIONS FROM PERSONS OTHER THAN MEMBER			j. STATE OR LOCAL WELFARE AID, INCLUDING AID TO DEPENDENT CHILDREN <i>(Include agency and address in Remarks section)</i> k. OTHER <i>(Specify)</i>		
h. SCHOLARSHIPS OR EDUCATIONAL GRANTS					
i. TAX REFUNDS <i>(Specify)</i>					
<b>14. MEMBER'S CONTRIBUTION</b>					
a. SHOW THE TOTAL AMOUNT THE MEMBER HAS CONTRIBUTED TO THE WARD'S SUPPORT FOR EACH OF THE PAST 12 MONTHS.					
MONTH AND YEAR	AMOUNT	MONTH AND YEAR	AMOUNT	MONTH AND YEAR	AMOUNT
b. MEMBER PROVIDES SUPPORT BY <i>(X one)</i>		ALLOTMENT	MONEY ORDER		
		PERSONAL CHECK	OTHER <i>(Explain)</i>		
<b>15. REMARKS</b>					
<b>16. SIGNATURES</b>					
Read the penalty provisions, sign and date the form, and have it notarized.					
<p><b>NOTE:</b> Whoever, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device, a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined as provided in Title 18, or imprisoned not more than 5 years, or both (U.S. Code, title 18, section 1001). The information provided in this form may be referred to the appropriate Military Service investigative agency.</p> <p><b>I make the foregoing claim with full knowledge of the penalties involved for willfully making a false claim. (U.S. Code, title 18, section 287, formerly section 80, provides a penalty as follows: Imprisonment for not more than five years and subject to a fine in the amount provided in this title.)</b></p>					
a. CUSTODIAN					
I/we _____ <i>(print name(s))</i> will immediately notify the service concerned of any change in child's financial circumstances, marital status, physical custody, or change in dependency upon the service member as shown in this form.					
(1) SIGNATURE OF PERSON WHO HAS CUSTODY OF THE WARD <i>(Can be member or other than member)</i>				(2) DATE SIGNED (YYYYMMDD)	
b. NOTARY PUBLIC					
Subscribed and duly sworn (or affirmed) to before me according to law by the above named affiant(s).					
This _____ day of _____, _____, at city (or town) of _____, county of _____, and state (or territory) of _____.					
			_____ <i>(Notary)</i>		
_____ <i>(Official Seal)</i>			_____ <i>(Official Title)</i>		
My commission expires: _____					
c. MEMBER					
(1) SIGNATURE				(2) DATE SIGNED (YYYYMMDD)	